D H E C
PROMOTE PROTECT PROSPER

REFERRAL FORM AND FOLLOW UP

TO: DIABETES EDUCATION PROGRAM AT _____
Contact: _____ Phone #: _____ Fax #: _____

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____
Street Address: _____ SS#: _____
City: _____ Phone #: _____ Cell #: _____

INSURANCE INFORMATION

Medicaid #: _____ Medicare #: _____
Private Insurance Name: _____ **PHONE #:** _____
Employer: _____ Insured Name: _____ ID #: _____

DIRECTIONS TO HOME: NOT NECESSARY

REASON FOR REFERRAL **Diabetes Self-Management Education**

CLINICAL INFORMATION

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** ☐ **Gestational** ☐ **Pre Diabetes**
Required Lab:
A1c _____ Date: _____ Triglycerides: _____ Date: _____ Microalbumin _____ Date _____
Total Cholesterol: _____ HDL: _____ LDL: _____ Date: _____

PATIENT EDUCATION ORDERS
Diabetes outpatient self-management training (up to total of 10 hours) includes these content areas as indicated by individual assessment 1) disease process, 2) acute complications, 3) nutritional management, 4) medications, 5) monitoring, 6) physical activity, 7) chronic complications, 8) psychosocial issues, 9) goal setting/problem solving, 10) pregnancy. Please check all that apply
Identify what type of education is requested:

☐ Group instruction with individual assessment **OR** ☐ Individual instruction due to (mark those that apply)
- ☐ Immediate need to begin insulin therapy
- ☐ Impediments to learning ability
- ☐ Diminished vision or hearing impairment

☐ ANNUAL follow up education (maximum of 2 hours of review)

PRECAUTIONS/ALERT RELATED TO HOME VISIT (IF APPLICABLE)

CERTIFY STATEMENT

I certify that diabetes self-management education services are needed under a comprehensive plan for this patient's care to ensure compliance with therapy and acquisition of skills and knowledge to manage diabetes.

Health Care Provider's signature/title _____ Date _____ Phone # _____

Print Name _____ Address _____

FOLLOW-UP RESPONSE

Admission Summary sent to provider on _____
If patient not seen return referral to provider
define reason that patient was not seen
- ☐ Unable to Contact Patient
- ☐ Patient does not desire diabetes education
- ☐ Other: _____

DHEC Provider's Signature _____

Date _____

Patient Label